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## COMMENTARY

# The Relevance of Power in Dentistry

R. Lala<sup>1</sup> , B.J. Gibson<sup>1</sup>, and L.M. Jamieson<sup>2</sup>

**Keywords:** decolonization, intersectionality, oral health inequalities, population health, racism, social norms

Dentistry has the overarching aim of improving oral health—both function and appearance—and reducing oral health inequalities. However, despite technological improvements, expansion of services, and decades of scholarship, oral health inequalities continue to persist. As an example, dental extractions are the leading cause of hospital admissions among UK children; and children who are from economically deprived communities are 4 times more likely to be admitted to hospital (Broomhead et al. 2020). Thus, the coveted aim of reducing oral health inequalities remains elusive. As such, we call for a change in tack, steering toward the analysis of power.

Theorizations and descriptions of power have a long, plural history. But in a broad sense, power is described as the capacity of actors to make change, as well as to receive and resist change (Lukes 2005). As such, the analysis of the effects of power in producing and receiving change which lead to inequalities and subsequent resistances has a rich, multidisciplinary, scholarly tradition. Nonetheless, beside a couple of notable exceptions, the explicit empirical analysis

of power has largely been ignored in dentistry (Nettleton 1992; Lala 2020).

Traditionally, to improve oral health and reduce inequalities, dentistry has predominantly focused on changing population norms such as eating less sugary foods, drinking more water (fluoridated and nonfluoridated), and visiting dental services. But norms do not occur in isolation; they are part of cultures. That is, people's behaviors are shared and are attached to shared values and meanings that have a history (traditions). As such, these norms are situated within the interests of diverse, powerful actors such as family, religion, media, commercial organizations, and healthcare. Since contemporary society is plural, it follows that population norms are not singular, but are diverse and tied to a range of shared meanings and values. For example, offering alcohol at weddings in most secular and Christian communities is associated with meanings of hospitality and celebration, whereas this would not be the case in most Muslim communities. Moreover, inequalities are not just economic, the principal focus of dental research and practice, but are multiple and intersectional.

We argue that it is only the analysis of power that demonstrates the conflicts

and contradictions across the economic, political, cultural, intellectual, and moral agendas that create messy, intersectional inequalities. Power analysis can give a nuanced understanding of the diverse and often conflicting interests of multiple actors that lead to differential norms within communities. These norms are often valued within communities, and disregarding or even attempting to suppress them, along with their meanings and traditions, is a form of colonialism.

Moreover, dentistry itself is also shaped by relations of power whose exercise can create inequalities. Nettleton (1992) showed how dentistry's prevention practice creates discourses (or knowledges) embedded with moral, gendered values. She argued that when dentists examine children's mouths, they create knowledge that differentially categorizes mothers as "natural," those who care for their children's teeth; "ignorant," those who do not; and "responsible," those who are not natural but can be taught by dentists to care for their children's teeth. Thus, the practice of dentistry itself disproportionately impacts women from economically deprived backgrounds who are more likely to be stigmatized as ignorant. Moreover, because children

DOI: 10.1177/2380084421998619. <sup>1</sup>Unit of Oral Health, Dentistry and Society, School of Clinical Dentistry, University of Sheffield, Sheffield, UK; <sup>2</sup>Australian Research Centre for Population Oral Health, Adelaide Dental School, The University of Adelaide, SA, Australia. Corresponding author: R. Lala, Unit of Oral Health, Dentistry and Society, School of Clinical Dentistry, University of Sheffield, 19 Claremont Crescent, Sheffield, S10 2TN, UK. Email: r.lala@sheffield.ac.uk



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from racial minorities have poorer oral health, this stigmatization is also highly racialized (Como et al. 2019). Thus, configurations of power are messy. On the one hand, dentistry is attempting to reduce inequalities through prevention practices. But on the other, those very same practices create complicated intersectional forms of inequalities rooted in race, gender, and class.

In another example, by undertaking a feminist analysis of power, Lala (2020) demonstrated how cosmetic dentistry practices create narrow, White-centered, gendered, heteronormative beauty ideals which disproportionately discriminate against women, gay communities, and people with obvious facial disfigurements. She showed how the dominant ideal of the straight white smile had an anti-Black historical context with attempts to make Black children look more “European” with orthodontic treatments. Thus, she argued that the Eurocentric ideal of straight white teeth endorsed across dental disciplines sits in relation to Whiteness and White power. Therefore, once again, the analysis of power revealed how dentistry’s exercise of power can create complex, intersectional forms of inequalities encompassing sexism, homophobia, racism, and disablism.

Consequently, the analysis of power in dentistry has shown that it furthers some interests and cultures and not others. And as such, dentistry itself can disempower and create multiple forms of inequalities. Thus, the analytics of power in dentistry is of importance for 6 reasons. First, it enables us to examine how the interests of powerful actors influence population norms, thus shifting attention to these actors that can effect change. Second, it reveals the complicated, intersectional forms of inequalities experienced by marginalized

communities, allowing a long-needed shift from the simplistic view that oral health inequalities are solely rooted in economic deprivation. Third, we can learn the meanings that are created through people’s behaviors that diverse communities value, which should deter us from unduly stigmatizing people who often face multiple, intersectional forms of inequalities. Fourth, it recognizes dentistry’s own power to create knowledge that is considered “fact” because it carries institutional legitimacy, but which is not value-free. We argue that since dental academic spaces are overwhelmingly White, the knowledge created in dentistry is embedded with Eurocentric values which needs long overdue reflection. Fifth, such due reflection will enable nuanced understandings of dentistry’s complicity in creating complicated, messy inequalities. Finally, it allows us to recognize the pluralist and diverse nature of contemporary society and thus appreciate that attempting to impose singular forms of behaviors, values, and knowledge that suppress the cultures of minoritized communities is a form of colonialism.

As such, we call for the wider use of feminist, postcolonial, and decolonial perspectives and methodologies in dentistry that pay attention to configurations of power. Moreover, these methods call for greater reflexivity in researchers to recognize their own role and power in creating knowledge which is not neutral. Specifically, these approaches will equip us to recognize dentistry’s complicity in perpetuating values that can counterproductively widen oral health inequalities.

### Author Contributions

R. Lala, contributed to conception and design, drafted the manuscript; B.J.

Gibson, L.M. Jamieson, contributed to conception and design, critically revised the manuscript. All authors gave final approval and agree to be accountable for all aspects of the work.

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### ORCID iD

R. Lala  <https://orcid.org/0000-0001-5604-967X>

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